Gray Davis, Governor
State of California
Business, Transportation and Housing Agency
980 Ninth Street, Suite 500
Sacramento, CA 95814
(916) 323-4209 voice
(916) 445-8399 fax
stang@dmhc.ca.gov e-mail

March 6, 2003

IN REPLY REFER TO FILE NO: 933 0318

Ms. Samia Zumout, Esq.
Director, Government Contracts And Regulatory Compliance
Access Dental Plan
555 University Avenue, Suite 182
Sacramento, CA 95825

RE: ROUTINE EXAMINATION OF ACCESS DENTAL PLAN

Dear Ms. Zumount:

Enclosed is the Final Report of a routine examination of the fiscal and administrative affairs of Access Dental Plan (the "Plan"), conducted by the Department of Managed Health Care (the Department"), pursuant to Section 1382(b) of the Knox-Keene Health Care Plan Act of 1975.[1] The Department issued a Preliminary Report to the Plan on November 14, 2002. The Department received the Plan's response on January 2, 2003

This Final Report includes a description of the compliance efforts included in the Plan's January 2, 2003 response, in accordance with Section 1382(c).

Section 1382(d) states "If requested in writing by the plan, the Director shall append the plan's response to the final report issued pursuant to subdivision (c). The plan may modify its response or statement at any time and provide modified copies to the department for public distribution not later than 10 days from the date of notification from the department that the final report will be made available to the public. The addendum to the response or statement shall also be made available to the public."

Please indicate within ten (10) days whether the Plan requests the Department to append its response to the final report. If so, please indicate which portions of the Plan's response shall be appended, and provide copies of those portions of the Plan's response exclusive of information held confidential pursuant to Section 1382(c), no later than ten (10) days from the date of the Plan's receipt of this letter.

If the Plan requests the Department to append a brief statement summarizing the Plan's response to the report or wishes to modify any information provided to the Department in its January 31, 2002 response, please provide the documentation no later than ten (10) days from the date of the Plan's receipt of this letter.

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Title 28, Division 1, Chapter 1, California Code of Regulations, beginning with Section 1300.43.

The Department will make the attached Final Report available to the public in ten (10) days from the Plan's receipt of this letter.

If there are any questions regarding this report, please call.

Sincerely,

Shelley Tang
Supervising Examiner
Office of Health Plan Oversight
Division of Financial Oversight

cc: Brent Seegmiller, Chief Financial Officer, Access Dental Plan
Andrew Meyers, Acting Assistant Deputy Director, Office of Health Plan Oversight
Mark E. Wright, Chief, Division of Financial Oversight
Kathleen McKnight, Counsel
Mabel Wu, Examiner
Patricia Mazzeo, Examiner

DEPARTMENT OF MANAGED HEALTH CARE

REPORT OF ROUTINE EXAMINATION

ACCESS DENTAL PLAN

FILE NO.: 933 0318

DATE: March 6, 2003

SUPERVISING EXAMINER: ELIZABETH PHILLIPS
EXAMINER-IN-CHARGE: MABEL WU

BACKGROUND INFORMATION FOR ACCESS DENTAL PLAN

Date Plan Licensed:	December 22, 1993
Organizational Structure:	The Plan was incorporated in California in 1993 to provide dental services to eligible subscribers for the Medi-Cal and Healthy Families programs. In January 1998, the Plan formed a majority-owned subsidiary, Premier Access, an indemnity specialty dental insurance company licensed by the California Department of Insurance. Premier Access provides dental insurance and related services primarily to California based employers.
Type of Plan:	Specialized dental plan. Staff model.
Provider Network:	Staff model facilities in Central and Northern California. At December 31, 2001, the Plan was operating 15 dental clinics.
Plan Enrollment:	166,540 enrollees as of September 30, 2002
Service Area:	Central and Northern California.
Date of Last Public Routine Financial Examination Report:	January 27, 1998

FINAL REPORT OF A ROUTINE EXAMINATION OF ACCESS DENTAL PLAN

This is the Final Report of a routine examination of the fiscal and administrative affairs of Access Dental Plan (the "Plan"), conducted by the Department of Managed Health Care (the "Department") pursuant to Section 1382(b) of the Knox-Keene Health Care Plan Act of 1975.[1] The Department issued a Preliminary Report to the Plan on November 14, 2002. The Department received the Plan's response on January 2, 2003.

This Final Report includes a description of the compliance efforts included in the Plan's January 2, 2003 response to the Preliminary Report, in accordance with Section 1382(c).

We examined the financial report filed with the Department for the quarter ended June 30, 2002, as well as other selected accounting records and controls related to the Plan's various fiscal and administrative transactions. Our findings are presented in this report as follows:

Section I.	Financial Report and Explanation of Reclassification
Section II.	Calculation of Tangible Net Equity
Section III.	Compliance Issues
Section IV	Internal Control Issues
Section V	Other Issues

Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any requests for additional corrective action contained within this report, within 30 days after receipt of this report.

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Title 28, Division 1, Chapter 1, California Code of Regulations, beginning with Section 1300.43.

SECTION I. FINANCIAL REPORT & EXPLANATION OF RECLASSIFICATION

A. BALANCE SHEET

BALANCE SHEET
AS OF JUNE 30, 2002

	Bal. per F/S @ 6/30/2002	Exam Adjustments Dr	Exam Adjustments Cr	Bal. per Exam @ 6/30/2002
Cash & Cash Equivalents	10,523,437			10,523,437
Short-Term Investments	988,242			988,242
Premiums Receivable	1,744,989			1,744,989
Interest Receivable	28,088			28,088
Shared Risk Receivables - Net				
Other Health Care Receivables - Net	1,039,432	(R-1)289,763		1,329,195
Prepaid Expenses	325,229			325,229
Secured Affiliate Receivables - Current				
Unsecured Affiliate Receivables - Current	0			0
Aggregate Write-Ins for Current Assets	1,987,234			1,987,234
TOTAL CURRENT ASSETS	16,636,651	289,763		16,926,414
Restricted Assets	50,000			50,000
Long-Term Investments	1,542,024			1,542,024
Intang. Assets & Goodwill- Net				
Secured Affiliate Receivables - Long-Term				
Unsecured Affiliate Receivables - Past Due				
Aggregate Write-Ins for Other Assets	84,232			84,232
TOTAL OTHER ASSETS	1,676,256			1,676,256
Land, Building and Improvements				
Furniture and Equipment - Net	664,882			664,882
Computer Equipment - Net	424,069			424,069
Leasehold Improvements - Net	359,497			359,497
Construction in Progress	1,008			1,008
Software Development Costs	45,527			45,527
Aggregate Write-Ins for Other Equipment	26,349			26,349
TOTAL PROP & EQUIP	1,521,332			1,521,332
TOTAL ASSETS	19,834,239	289,763		20,124,002

BALANCE SHEET
AS OF JUNE 30, 2002

	Bal. per F/S @ 6/30/2002	Exam Adjustments Dr	Exam Adjustments Cr	Bal. per Exam @ 6/30/2002
Trade Accounts Payable	258,070			258,070
Capitation Payable	688			688
Claims Payable (Reported)	1,902,096			1,902,096
Incurred But Not Reported Claims	2,565,762			2,565,762
POS Claims Payable (Reported)				
POS Incurred But Not Reported Claims				
Other Medical Liability	250,635			250,635
Unearned Premiums	799,806			799,806
Loans and Notes Payable				
Amounts Due to Affiliates – Current	0			0
Aggregate Write-Ins for Other Liabilities	2,125,211	(R-1)	289,763	2,414,974
TOTAL CURRENT LIABILITIES	7,902,267		289,763	8,192,030
Loans and Notes Payable (Not Subordinated)				
Loans and Notes Payable (Subordinated)				
Accured Subordinated Interest Payable				
Amounts Due to Affiliates - Long Term				
Aggregate Writ-Ins for Other Liabilities				
TOTAL OTHER LIABILITIES				
TOTAL LIABILITIES	7,902,267		289,763	8,192,030
Minority Interest	1,765,105			1,765,105
Common Stock	300,000			300,000
Preferred Stock				
Paid in Surplus	344,757			344,757
Contributed Capital				
Retained Earnings Deficit/Fund Balance	9,522,108			9,522,108
Aggregate Write-Ins for Other Net Worth Items				
TOTAL NET WORTH	10,166,865			10,166,865
Rounding	2			2
TOTAL LIAB & NET WORTH	19,834,239	0	289,763	20,124,002

B. INCOME STATEMENT

STATEMENT OF INCOME AND EXPENSES
AS OF JUNE 30, 2002

	Bal. per F/S @ 6/30/2002	Exam Adjustments Dr	Exam Adjustments Cr	Bal. per Exam 6/30/2002
Premium	7,955,666			7,955,666
Capitation	227,902			227,902
Co-payments, COB, Subrogation	529,196			529,196
Title XVIII – Medicare				
Title XIX – Medicaid	6,636,569			6,636,569
Fee-For-Service	3,964,881			3,964,881
Point-of-Service (POS)				
Interest	121,448			121,448
Rish Pool Revenue				
Aggregate Write-Ins for Other Revenue	(121,420)			(121,420)
TOTAL REVENUES	19,314,242			19,314,242
Primary Professional Services - Capitated	3,278,684			3,278,684
Primary Professional Services(Non-Capitated)	6,832,421			6,832,421
Other Medical Professional Services - Capitated	1,651,929			1,651,929
Other Medical Professional Services(Non-Capitated)				
Non-Contracted ER Room and Out-of-Area Expense				
Aggregate Write-Ins for Other Med & Hospital Expenses	925,880			925,880
TOTAL MEDICAL AND HOSPITAL	12,688,914			12,688,914
Compensation	1,181,864			1,181,864
Interest Expense	4,110			4,110
Occupancy, Depreciation and Amortization	189,996			189,996
Management Fees	0			0
Marketing	1,324,755			1,324,755
Affiliate Administration Services	0			0
Aggregate Write-Ins for Other Administration	971,243			971,243
TOTAL ADMINISTRATION	3,671,968			3,671,968
TOTAL EXPENSES	**16,360,882**			**16,360,882**
INCOME (LOSS)	**2,953,360**			**2,953,360**
Provision for Taxes	367,617			367,617
NET INCOME (LOSS)	**2,585,743**			**2,585,743**

C. EXPLANATION OF EXAMINATION ADJUSTMENTS

RECLASSIFYING JOURNAL ENTRIES

ENTRY #	ACCOUNT NAME	DEBIT	CREDIT
R1	Other Health Care Receivable	$289,763	
	Other Aggregate liabilities		$289,763
	To properly reclassify a credit balance in A/R as a payable		

The Plan was required to provide assurance that either this reclassifying journal entries has been posted to your books and records or provide an explanation regarding its disposition.

The Plan responded by stating that the Journal entry has been posted to the books and records of the Plan.

The compliance efforts described above are responsive to the deficiency cited.

Section II. CALCULATION OF TANGIBLE NET EQUITY ("TNE")

Net Worth per Examination @ June 30, 2002 (from Section I)	10,166,865
Add: Subordinated Debt	0
Less: Access Dental - Receivable From Officers, Directors, and Affiliates	(965,342)
Premier Access – Receivable From Officers, Directors, and Affiliates *	(950,217)
Tangible Net Equity @ June 30, 2002	8,251,306
Required Tangible Net Equity @ June 30, 2002	(1,541,328)
Excess Tangible Net Equity @ June 30, 2002	6,709,978

At June 30, 2002, the Plan was in compliance with the TNE requirements of Rule 1300.76 as it relates to the adequacy of TNE.

*This balance, deducted in our calculation of TNE, consisted of three receivables from relatives and a friend of Dr. Abbaszadeh, owner of the Plan. These receivables are deducted from TNE, as required by Rule 1300.76, which requires that receivables from related parties, which are not in the normal course of business, be deducted from TNE.

Our examination disclosed that the Plan has not deducted the loans made by Premier Access to relatives and a friend of the owner of the Plan in its calculation of TNE that is included with periodic financial filings filed with this Department.

The Plan was required, in the future, to deduct all receivables from related parties that are either not in the normal course of business or not current, in calculations of TNE filed with this Department.

The Plan responded that the Plan has and will deduct all receivables from related parties that are either not in the normal course of business or are not current, beginning with the quarter ended September 30, 2002 financial statements filed with this Department.

The Plan also responded that the individual who routinely prepares this calculation for the Plan has been instructed on this matter and a reminder has been placed in the calculation work papers to ensure ongoing compliance. The Chief Financial Officer is responsible for ensuring ongoing compliance with this corrective action.

The compliance efforts described above are responsive to the deficiency cited.

Section III. COMPLIANCE ISSUES

A. CLAIMS REIMBURSEMENT

Section 1371 requires a specialized service plan to reimburse claims within thirty (30) working days after receipt of the claim, unless the claim is contested or denied by the plan. Section 1371 also requires that if the claim is contested by the plan, the claimant shall be notified, in writing, that the claim is contested, within 30 working days after receipt of the claim by the health care service plan. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim.

Our examination disclosed that out of the total claims processed from June 1, 2001 to July 17, 2002, approximately 3.3% of claims were adjudicated beyond the thirty (30) working days allowed by Section 1371. Also, our examination indicated that out of the 61 claims selected for review, 42 claims were processed beyond statutory time allowed.

The Plan was required to submit a Corrective Action Plan which Access Dental Plan has implemented to ensure compliance with Section 1371. Include procedures for monitoring compliance with Section 1371. Provide the management position that has the responsibility for implementing the Corrective Action Plan, and also ongoing compliance with this Section.

The Plan responded that the Plan has implemented a new Claims Aging Report since September, 2002. The Claims Manager runs this report on a weekly basis to track and prevent claims from exceeding the thirty-day requirement. Since the implementation of the new claims aging report, no claims have been found to be in violation of the thirty-day requirement contained in Section 1371. The Claims Manager is responsible for overseeing this corrective action.

The compliance efforts described above are responsive to the deficiency cited.

B. PAYMENT OF INTEREST

Section 1371 states that if an uncontested claim is not reimbursed within the thirty (30) working day period, interest shall accrue at the rate of fifteen percent (15%) per annum beginning with the first calendar day following the thirty (30) working day period. A health care service plan shall automatically include in its payment of the claim all interest that has accrued pursuant to this section without requiring the claimant to submit a request for the interest amount. Any plan failing to comply with this requirement shall pay the claimant a ten-dollar ($10) fee.

Our examination disclosed that the Plan did not pay interest on uncontested claims, including the supplemental encounter claims that were paid later than thirty (30) working days after the receipt of the claim. Our examination also indicated that the Plan does not have a policy to pay interest on late paid claims.

The Plan was required to provide a Corrective Action Plan that provides for the identification of all claims, including supplemental encounter claims, paid since January 1, 1996 on which interest should have been paid and has not been paid. The Plan should then pay the interest and the $10 fee where appropriate. This corrective action may not be completed by the date of your response, and if so provide a time frame in which the payments will be made.

The Plan was also required to provide the management position responsible for ensuring that the Plan remains in compliance with Section 1371. Also, the Plan is required to establish procedures to pay interest on late claims and include a description of such procedures in your response.

The Plan responded by stating the following:

1. We identified "late claims" paid through September of 2002 and remitted to the respective claimants interest and late fees as required by Section 1371 in October 2002. The total of the interest and late fees paid was $10,238, of which $1,678 was in interest and $8,560 in late fees.

2. It is the Plan's policy to pay interest automatically, without requiring submission of a request from an associated claimant, at a rate of 15 percent per annum beginning with the thirty-first business day after the receipt of an uncontested claim through the claim payment date. Additionally, a fee of $10 is to be paid to each respective claimant if interest owing is not automatically paid.

3. Currently, the Plan's claim system does not have the capability to include interest payments with claim payments. However, within thirty days after the end of each calendar quarter, the Plan identifies late claims, if any, paid within the quarter and makes interest payments to the claimants. The ability to pay interest with the associated claim payment is an expected feature

of a new system the Plan is currently evaluating. The Claims Manager is responsible for overseeing this corrective action.

The compliance efforts described above are responsive to the deficiency cited.

C. STATUS OF CLAIMS

Rule 1300.77.4 requires all plans to institute procedures whereby all claims can be tracked and accounted for from the date received until they are fully resolved. This system must allow for the determination of the date of receipt of any claim, the status of the claims, the dollar amount of unpaid clams at any time and for the rapid retrieval of any claim.

Our examination disclosed that the Plan does not have a system to allow for the determination of the date of receipt, the status of the claims, the dollar amount of unpaid claims at any time or for rapid retrieval of any claim, as follows:

- Claims are not entered into the system until they are processed.
- Five (5) out of 61 claims were lost after they were received by Plan. Providers have to submit a second claim for payments.
- Claims of Premier Access and claims of the Plan are mailed to the same address. If the address on the envelope is to Premier Access, the documentation inside the envelope will be sent to Premier Access without separating the documentations of Premier Access and Plan by the mail-room clerk. Two out of 61 claims were paid late because the Plan's claims were incorrectly sent to Premier Access and were not forwarded to the Plan in a timely manner for processing.
- Claims, especially encounter supplemental claims, were sent to the encounter desk instead of the Claim Department and set aside without immediate follow-up. Our examination disclosed that approximately 20.7% of supplemental encounter claims were adjudicated beyond the thirty (30) working days allowed by Section 1371.

The Plan was required to detail the measures taken to ensure compliance with Rule 1300.77.4. Also, state steps taken to ensure proper tracking of claims, the date the corrective action was implemented, the management position responsible for overseeing the corrective action and the controls implemented for ongoing monitoring for continued compliance.

The Plan responded by stating the following:

1. The claims intake and processing system of the Plan was modified and enhanced effective December 2, 2002. Modifications and enhancements that were implemented include the following:
    - Received claims are now accumulated into batches of 50.
    - Batches are placed in a chronological "to input" file.
    - Claims are released to data entry personnel for input into the claims system. An adjudicator reviews the claims before payment.

- A unique claim number is assigned and documented on each claim allowing for tracking and retrieval.
- Establishment of additional categories of claims status in order to comply with the requirements of Rule 1300.77.4. Status categories are currently as follows:
    - Entered
    - In-process
    - Processed – Ready for review
    - Processed – Ready for payment
    - Paid
    - Denied

2. Additionally, two new staff positions in the claims department have been added to handle the encounter information.

3. During January 2003, separate post office boxes will be established for Access Dental and Premier Access Insurance Company. This will help prevent the mixing of claims that in the past has occasionally resulted in claims not being paid in a timely manner.

4. The Claims Manager is responsible for overseeing the implementation and ongoing monitoring of this corrective action.

The compliance efforts described above are responsive to the deficiency cited.

D. ADMINISTRATIVE CAPACITY

1. NON-EMPLOYEES PERFORM DISCRETIONARY FUNCTIONS OF PLAN

Section 1367(g) requires a plan to have the organizational and administrative capacity to provide services to subscribers and enrollees. Rule 1300.67.3(a)(2) requires the plan to have staffing in fiscal and administrative services sufficient to result in the effective conduct of the plan's business.

To demonstrate adequate administrative capacity, a plan must have an executive staff and support staff, which is properly dedicated to performing the necessary functions of a health care service plan. While a plan may make contractual arrangements for nondiscretionary, ministerial services, any function that requires the exercise of any judgment, decision-making or discretion must be plan management's responsibility. Also, the responsibility for the day-to-day functions and the oversight of any delegated function must reside with plan management.

Our examination disclosed that the Treasury Manager and the Controller were not employees of the Plan. They were employees of the Plan's sister company, Sierra Professional Services and performed discretionary functions on behalf of Plan.

Plan management has stated that these two employees will be transferred to the Plan beginning November 2002. The Plan submitted an amendment to the Department on October 11, 2002 notifying the Department of the transfer of the two employees.

No action is required by the Plan.

2. CLAIM PROCESSING

Our examination disclosed that Premier Access processes claims related to the Geographic Managed-Care (GMC) product on behalf of the Plan. However, the Administrative Services Agreement between Premier Access and Plan does not support this arrangement. During the examination, our examiner was informed that the Plan intends to transfer the GMC claim processing function back to the Plan.

The Plan was required to provide a time frame in which the claim processing function will be transferred to the Plan and provide the management position responsible for making this change.

The Plan responded by stating that the transfer of the GMC claims processing function back to the Plan will occur during the first calendar quarter of 2003. The Chief Executive Officer is responsible for overseeing the implementation and ongoing monitoring of this corrective action.

The compliance efforts described above are responsive to the deficiency cited.

E. BOOKS AND RECORDS

Rule 1300.85.1 requires every plan to preserve for a period of not less than five years, the last two years of which shall be in an easily accessible place at the offices of the plan or solicitor firm, the books of account and other records required under the provisions of, and for the purpose of the Act. After such books and records have been preserved for two years, they may be warehoused or stored, or microfilmed, subject to their availability to the Director within not more than 5 days after request therefore.

1. RETENTION OF CLAIMS

Our examination disclosed that five (5) out of the 61 claims selected for our review were misplaced following their receipt by Plan and that the providers had to submit a second claim for payment.

The Plan was required to provide the detailed measures taken to ensure compliance with Rule 1300.85.1. The Plan was also required to state the steps taken to ensure proper tracking of claims, the date the corrective action was implemented, the management position responsible for overseeing the corrective action, and the controls implemented for ongoing monitoring for continued compliance as described in paragraph C above.

The Plan responded by stating the following:

1. We will not transfer received claims to offsite storage until two years after the date of processing. Claims will be preserved for a period of not less than five years and are to be available to inspection by the Director of the Department within 5 days after request therefore.

2. To prevent the misplacement of claims the claims intake and processing system was enhanced effective December 2, 2002 as follows:

    - Received claims are now accumulated into batches of 50.
    - Batches are placed in a chronological "to input" file.
    - Claims are released to data entry personnel for input into the claims system. An adjudicator reviews the claims before payment.
    - A unique claim number is assigned and documented on each claim allowing for tracking and retrieval.

3. The Claims Manager is responsible for overseeing the implementation and ongoing monitoring of this corrective action.

The compliance efforts described above are responsive to the deficiency cited.

2. NOTIFICATION OF CONTESTED AND/OR DENIED CLAIMS

Our examination disclosed that Plan did not keep records of denial letters sent to providers, or letters requesting additional information.

The Plan was required to provide assurance that the Plan has implemented a Corrective Action Plan to ensure that a record of the notifications of contested and/or denied claims sent to providers be retained by the Plan.

The Plan responded by stating effective September 2002, a copy of each denial letter is now attached to each denied claim and retained on file. The Claims Manager is responsible for overseeing the implementation and ongoing monitoring of this corrective action.

The compliance efforts described above are responsive to the deficiency cited.

F. AMENDMENTS/MATERIAL MODIFICATION TO PLAN APPLICATION

Section 1352(a) and (b) and Rules 1300.52 and 1300.52.1 require all plans to file an amendment with the director within thirty (30) days after any changes in the information contained in its application, other than financial or statistical information. Material changes to the plan's operations are required to be filed as a Notice of Material Modification thirty (30) days prior to any changes being implemented as specified in this Section and Rules.

1. LINES OF CREDIT

Our examination disclosed that the Plan has two lines of credit with Sacramento Commercial Bank with a maximum credit limit of $4,000,000. The two lines of credit were not filed with the Department.

The Plan was required to file documentation with the Department, supporting the two lines of credit.

The Plan responded by stating that it will file these lines of credit with the Department on before January 31, 2003. The Chief Financial Officer is responsible for overseeing this corrective action.

The compliance efforts described above are responsive to the deficiency cited.

LOANS TO RELATED PARTIES

Our examination disclosed that several loans in the total of $965,342 were issued by the Plan to related parties. However, the documentations supporting these arrangement were not filed with the Department.

The Plan was required to file the documents related to these loans with the Department.

The Plan responded by stating that it will file the documents associated with these loans with the Department on or before January 31, 2003. The Chief Financial Officer is responsible for overseeing this corrective action.

The compliance efforts described above are responsive to the deficiency cited.

3. ADMINISTRATIVE SERVICE AGREEMENT WITH SIERRA PROFESSIONAL SERVICES

Our examination disclosed that Sierra Professional Services, a sister company of Plan, provided administrative services on behalf of the Plan since late 2001. However, the Plan did not file an administrative service agreement until May 13, 2002. The filing is still pending for Department's review.

The Plan was reminded that within thirty (30) days after any non-material changes in the information contained in its application, other than financial or statistical information, an amendment is required to be filed as required by Section 1352(a) and (b) and Rules 1300.52 and 1300.52.1.

The Plan was required to provide assurance that in the future the Plan will make all filings with the Department within the time frame stated in the Act and Regulations.

The Plan responded that in the future, it will make all such filings with the Department within the time-frame stated in the Act and Regulations. The Chief Financial Officer is responsible for overseeing the timely submission of this category of filing.

The compliance efforts described above are responsive to the deficiency cited.

G. CONSOLIDATED FINANCIAL STATEMENTS

Rule 1300.84 (c) states, in part, that "financial statements of a Plan required pursuant to these rules must be on a combing basis with an affiliate, if the plan or such affiliate is substantially dependent upon the other for the provision of health care, management or other services." Rule 1300.84 (f) further states that "plans which have subsidiaries that are required to be consolidated under generally accepted accounting principles must present either (1) consolidating financial statements, or (2) consolidating schedules for the balance sheet and statement of operations, which in either case must show the plan separate from the other entities included in the consolidated balances."

ARB-51, as amended by FAS-94, requires that all investments in which a parent company has a controlling financial interest represented by the direct or indirect ownership of a majority voting interest (more than 50%) be consolidated.

Our examination disclosed, the Plan has 72.46% ownership of Premier Access, therefore, the Plan was required to prepare its financial statements on a consolidated basis with Premier Access, and also file consolidated financial statements with the Department. However, the Plan has, historically, filed the financial statement **of the Plan only**. (The consolidating schedules have been filed as supplemental information.)

It should be noted that Section I. A & B of this report presents the Plan's financial information on a consolidated basis.

The Plan was required to provide assurance that the Plan's financial statements filed with the Department are prepared on a consolidated basis. Furthermore, give assurance that the footnotes to the financial statements will relate to the consolidated financial statements, not to the Plan only.

The Plan responded that the Plan has filed the financial statements with the Department, prepared on a consolidated basis, effective with the quarter ended September 30, 2002. Furthermore, the footnotes to the financial statements relate to the consolidated financial statements, not to the Plan only. The Chief Financial Officer is responsible for the implementation and ongoing monitoring of this corrective action.

The compliance efforts described above are responsive to the deficiency cited.

Section IV. INTERNAL CONTROL

Section 1384, 1345 (s), and Rule 1300.45(q) include requirements for filing financial statements in accordance with generally accepted accounting principles and other authoritative pronouncements of the accounting profession.

Statement on Auditing Standards (SAS) No. 78 states "Internal control is a process---effected by an entity's board of directors, management, and other personnel---designed to provide reasonable assurance regarding the achievement of objectives in the following categories: (a) reliability of

financial reporting, (b) effectiveness and efficiency of operations, and (c) compliance with applicable laws and regulation."

SAS No. 60 requires an auditor to communicate reportable conditions noted during the examination to appropriate personnel. Reportable conditions involve matters coming to the auditor's attention relating to significant deficiencies in the design or operation of the internal control structure, which could adversely affect the organizations ability to record, process, summarize, and report financial data consistent with the assertions of management in the financial statements.

As a result of our examination procedures, we noted the following weaknesses in internal controls:

A. SIGNATORIES ON PLAN'S BANK ACCOUNTS

Our examination disclosed, the signature authority over the Plan's bank accounts is extended to an individual who is not an officer or employee of the Plan. This exposes the Plan's assets to external control and possible misappropriation.

The Plan filed, on October 17, 2002, an amendment to transfer the employee to the Plan effective November 1, 2002. The filing is being reviewed by the Department.

No action is required.

B. CREDIT BALANCES IN FEE-FOR-SERVICE RECEIVABLE AGING

Our examination disclosed, that the Accounts Receivable aging includes credit balances related to prepayments of membership, refunds, posting errors, etc. The total of the credit balances is $289,762. Such credit balances should be investigated and eliminated from the aging.

The Plan was required to state the Corrective Action Plan for the investigation and elimination of the credit balances on the fee for service receivable aging. Also, provide the management position responsible for the implementation of the Plan, and for providing ongoing oversight over the aging schedule.

The Plan responded by stating the following:

1. Credit balances in patient accounts occur for various reasons during the normal course of operations. It is company policy for office managers to evaluate these balances on a monthly basis to prevent or minimize their accumulation. Office managers were reminded of this policy during 2002 and will be reminded again during January of 2003.

2. A schedule has been established for the office managers that sets forth a systematic approach and timetable for the investigation and settlement of the current accumulated credit balances. The successful implementation of this corrective action plan will result in the immediate prevention of additions to the accumulation of credit balances and the resolution of the past accumulation of credit balances by October 31, 2003. This corrective action will

be implemented in January 2003 and the Vice President of Clinical Operations is responsible for its implementation and ongoing monitoring.

3. Credit balances in patient accounts have historically been netted against patient receivables. However, pursuant to direction received from the department as noted in Section I above, these credit balances are now reported as Aggregate Other Liabilities in the Plan's financial statements. Implementation and ongoing monitoring of this corrective action is the responsibility of the Chief Financial Officer.

The compliance efforts described above are responsive to the deficiency cited.

C. UNAPPLIED DEPOSIT

A balance of $93,434.73, classified as Unapplied D'CAL Deposit, was reported as a credit balance to offset an Other Health Care Receivable. This balance could not be supported by the Plan. It represented payments received by staff offices four years ago from the Department of Health Service for services provided to Denti-Cal patients but not yet applied to the individual patient accounts.

The Plan was required to resolve this balance and apply the payments to the patient accounts as appropriate.

The Plan responded by stating that it has resolved this balance and the payments applied. This corrective action was completed in December 2002 under monitoring by the Chief Financial Officer.

The compliance efforts described above are responsive to the deficiency cited.

D. LOANS RECEIVABLE NOT SUPPORTED BY WRITTEN DOCUMENTATION

Our examination disclosed, the Plan has several loans receivable, with a total balance of $170,570, which is not supported by written documentation describing the amount of the loans, the terms of repayment, and the acceptance of such terms by the borrower. It is good business practice, and an essential internal control, to maintain such documentation.

Please include, with your response, a copy of the written documentation that has been set in place to support these loans.

The Plan responded by stating the following:

1. Effective immediately, the Plan requires that all loans receivable be supported by written documentation describing the amount of the loan, the terms of repayment, and the acceptance of such terms by the borrower.

2. Included as Attachment I, there is a listing of the loans that comprise the $170,570 that was outstanding at the date of examination. Attachment I discloses the current balances of those loans and any loans made subsequent to the date of examination. A copy of the associated

loan documentation on any loans receivable with a balance remaining at December 31, 2002 is provided as Attachment II.

3. The Chief Financial Officer is responsible for the implementation and ongoing monitoring of this corrective action.

The compliance efforts described above are responsive to the deficiency cited.

Section V. OTHER ISSUES

A. FINANCIAL STATEMENT REPORTING - REPORT # 4 ENROLLMENT

Section1356(f) states that for the purpose of calculating the assessment under this section, an enrollee who is enrolled in one plan and who receives health care services under arrangements made by another plan or plans, whether pursuant to a contract, agreement, or otherwise, shall be considered to be enrolled in each of the plans.

Our examination disclosed that Plan does not record in Report #4: Enrollment And Utilization Table to the DMHC financial statements, the enrollees who are sub-capitated to the Plan from Delta Dental Plan and receive dental services in the Plan's staff offices. Furthermore, these enrollees have not been included in the calculation of the Plan's Annual Assessment.

The Plan was required to provide assurance that, in the future, Report #4: Enrollment And Utilization Table filed with this Department will include all enrollment, including those on which the Plan has received capitation from Delta Dental Plan.

The matter of underpayment of the Annual Assessment has been referred to the Office of Enforcement for administrative action.

The Plan responded by stating "effective with the quarterly financial report for the quarter ended September 30, 2002, the Plan now includes the enrollees who are capitated to the Plan from Delta Dental Plan in Report #4: Enrollment And Utilization Table. The Chief Financial Officer is responsible for the implementation and ongoing monitoring of this corrective action."

The compliance efforts described above are responsive to the deficiency cited.

B. NON-ROUTINE EXAMINATION

The Plan is advised that the Department may conduct a non-routine examination, in accordance with Rule 1300.82.1, to verify representations made to the Department by the Plan in response to the Report. The cost of such examination shall be charged to the Plan in accordance with Section 1382(b).

No response is required to this Section.